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Patients, Prose, and Poetry: The Medical and Literary World of William Carlos Williams

A thesis submitted in partial fulfillment of the requirement
for the degree of Bachelor of Arts in English from
The College of William and Mary

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Patients, Prose, and Poetry: The Medical and Literary World of William Carlos Williams

Honors English Thesis By Sarah Heins
Fall 2017

*To my Grandfather, Dr. Stephen J Prevoznik—the physician-writer who has been and always
will be my lifelong inspiration.*

*And to my Grandma, Rita K. Prevoznik—the woman who keeps his legacy alive every day for
both me and for the incredible family they have created.*

Sarah Heins

Professor Christopher MacGowan

English Honors

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Patients, Prose, and Poetry: the Medical and Literary World of William Carlos Williams

“All that I have wanted to do was to tell of my life as I went along practicing medicine and at the same time recording my daily search for...what? As a writer I have been a physician, and as a physician a writer” —*William Carlos Williams (Autobiography xii)*

William Carlos Williams—the Pulitzer Prize and National Book Award winning doctor-writer most famous as a modernist poet—strove for innovation in his prose and poetry portrayals of the realities of his everyday world. Writing during the first half of the 20th century, when sweeping changes in politics, science, education, and perceptions of identity sparked the cultural experiment of the modernist movement, Williams was among those who desired to remake poetry itself: to create a new line and structure while simultaneously communicating the nuances of daily life. Williams wanted an original, experimental poetry that was rooted in the local and commonplace, striving to push newness and innovation while simultaneously appealing to a wide audience. However, Williams also wanted his experimental, locally-based writing to meet an international standard and equal the achievements of his expatriate contemporaries. The tension between these goals—revolutionizing form and style, writing for and of the people, and still matching the excellence of modernist work being produced in Europe—posed Williams with a challenge that pervaded his literary career. This challenge that the writer set for his relations with his audience is paralleled by another challenge central to Williams’s life and writings: that of the relationship between doctor and patient.

Driving the literary side of these parallel communication-based challenges, Williams's aim to express his local American world in a new and unorthodox style that could also be accessible to a wide readership drew him into a difficult balancing act. In his 1917 poem, "January Morning: Suite," Williams explores the struggles of a poet wanting to communicate but struggling with audience connection. The poem begins with descriptions of various scenes from daily New Jersey life as seen through the routine of a local doctor. The physician sees: "neatly coiffed, middle aged gentlemen/with orderly moustaches and well- brushed coats" and rides a Manhattan ferry while studying "curdy barnacles and broken ice crusts/left at the slip's base by the low tide" (*CPI* 101, 102). Despite its everyday subject matter, the poem's form is fragmented and the speaker insists that its reading demands focused attention. Although it deals with the everyday world, poetry is not easy. As Williams's poem continues:

All this—
 was for you, old woman.
 I wanted to write a poem
 that you would understand.
 For what good is it to me
 if you can't understand it?
 But you got to try hard—
 (*CPI* 103)

Williams's desire for this woman to understand his writing demonstrates his investment in effectively reaching his reader. The speaker's asking, "what good is it to me/if you can't understand it?" insists that the audience's grasp of the poem is vital, while his later statement that "you've got to try hard" claims that both parties hold responsibility for communication.

Williams's difficulties naming his 1917 collection, *Al Que Quiere!* further demonstrate the antagonism between his poetic goals and ability to reach his intended audience. Williams considered two possible titles for this work, with his main concern being how to make the collection's name easily understandable yet still representative of the poems within. Williams

wrote to Marianne Moore in a 1917 letter that he initially planned to call his collection “AL QUE QUIERE!”—which means: To him who wants it.” However, he recognized its Spanish name as out of place and said it “is not democratic—does not truly represent the contents of the book.” He thus added a second line to the title, calling it “AL QUE QUIERE! or THE PLEASURES OF DEMOCRACY.” Though Williams liked “this conglomerate title,” which he felt more fully embodied the nature of his work, his “publisher objects,” pulling Williams between fulfilling his poetic aims and achieving audience understanding (*SL* 40). Ultimately, Williams chose the shorter, ‘less democratic’ title.

A third manifestation of Williams’s difficulty marrying his poetic goals with wider audience communication is in the fact that the majority of his local readers did not understand his writing. One of Williams’s main goals, as articulated by Eric White, was to both portray and “provoke a meaningful dialogue” with local townspeople (White 13). However, Williams often found that his poetry was inaccessible to the citizens of his community. In an interview with Edith Heal, Williams’s wife, Flossie, comments on the challenges Williams faced in connecting to his local audience. She first explains that hers and Williams’s own families were often puzzled by Williams’s poetics, as they would “shake their heads and say, ‘but such language... and blah blah blah!’” when he shared his writing (Heal 9). Furthermore, the audience in his hometown of Rutherford was especially puzzled by his work. In his biography of Williams, Paul Mariani explains that when featured at meetings of Rutherford’s “Polytopics” club—a group intended to discuss and maintain their community’s cultural perspective—Williams found that his poems were often misinterpreted (Mariani 138). Flossie explains later in her interview with Heal, “there were no literary connections in Rutherford. I asked him not to read his poetry... where he was misunderstood and parodied,” as she demonstrates how the people of Williams’s intended local

audience “don’t know what its about” (Heal 10). In his draft of the prologue to a special edition of his improvisational book, *Kora in Hell*, Williams himself recognizes the difficulty and lack of clarity in the work, asking himself: “What to do with it? It would mean nothing to the reader” (*KIH* Draft Beinecke 2).

Williams’s letters also reveal his struggle with bringing his literary work to a wider audience. He writes to fellow poets and to magazine editors about his publishing difficulties, often discussing low readership and poor return on sales. In letters to his publisher James Laughlin, especially, Williams laments his broken connection with his audience and discusses the struggles of gaining his readers’ admiration and understanding while staying true to his unorthodox style. In fact, until partnering with Laughlin at New Directions, Williams struggled to find a long-term publisher who would consistently put out his works and help him establish a strong, regular readership. Until the last dozen years of his life, Williams was mainly published in small circulation magazines while his books appeared only in small-print runs, further preventing him from reaching the wide readership he desired.

Alongside his lifelong career as a writer, Williams also worked as a family physician in the socioeconomically eclectic New York City suburb of Rutherford, NJ and its surrounding towns. In this career, Williams encountered patients who were often poor, illiterate, afraid, and perhaps even silent or angry, creating circumstances that made communication between doctor and patient difficult. In his medical prose narratives and some of his poems, these doctor-patient conflicts serve as another, parallel manifestation of the larger issue of a specialist interacting with his target population. Williams’s medical stories and poems often illustrate such conflicts in terms of two opposing sides of medicine: the professional and the interpersonal. As George Monteiro states of Williams’s medical narratives, “the point in calling them a doctor's stories is

that at their best they draw...upon his embodied conflicts between his learned professionalism and his affective impulses” (Monteiro 77). These two overarching aspects of the medical experience clash in a series of sub-conflicts between professional and interpersonal elements such as objectivity and emotion, physical and mental health, and, finally, a modern, scientific medical approach and the older-style of intuitive, holistic practice. Such conflicts stir tension and drama that shape the doctor-patient relationship and drive Williams’s medical narratives as they explore the roots and consequences of, as well as possible means of managing, these largely unresolvable tensions.

The primary conflict that Williams explores within the doctor-patient exchange is that between objective observation and emotional engagement. As many of his stories demonstrate via what Sherwin Nuland describes as Williams’s physicians’ tendencies to “make good use of what can be learned by scrupulous observation of the interplay between disease, themselves, and the sick,” effective treatment requires doctors to be impartial and open-minded, focusing on observed symptoms and attending to their patients’ medical needs without the superfluous influence of emotion (Nuland vii). However, these accounts of doctors treating ailing mothers or compromising with obstinate children also show that the physicians’ personal reactions—in the forms of both sympathy for the patient and in the doctor’s own appraisal of the situation at hand—are unavoidable, and thus clash with objectivity. Dr. Martin Donohue, in his article for physicians of the Alpha-Omega-Alpha Honor Medical Society, notes this dichotomy in Williams’s writings and argues that while he “advised physicians to maintain their composure at all times,” Williams also “stroved to foster healthy relations between himself and his patients” and “wished...to grow closer to them” explicitly demonstrating the two-sided perspective on emotion’s place in the medical realm (Donohue 15).

Within this larger emotion versus objectivity conflict, one of Williams's physicians' greatest obstacles is controlling the levels of sympathy and attachment to patients. In Williams's stories, personal feelings can cloud proper judgment and make practice in a world of suffering and sadness overwhelming. As Donohue explains about these stories, "the constant intrusions of the sick into a physician's personal life could jeopardize the doctor-patient relationship" and even the entire treatment process (Donohue 15). Dr. David Lehman, however, disagrees. In his article for *JAMA* on the value of emotional connections in medical interactions, Lehman argues that "some physicians have overly developed their critical minds and place too much emphasis on objective observation, excluding emotionalism." He explains that an overly detached doctor does little good for a fearful patient, and failure to acknowledge emotional needs prevents effective treatment. For Lehman, Williams's doctor narrators must therefore "occupy a middle-ground of ardent involvement and professionalism," balancing their observation with empathy to form stable patient relationships (Lehman 65).

"Jean Beicke," one of Williams's most famous stories, provides the richest exploration of a doctor's struggle between objectivity and empathy. In this story, Williams's narrator works in a hospital treating impoverished children coming from horrendous conditions. He explains that when patients arrive, they are "stinking dirty...almost dead sometimes, just living skeletons, almost, wrapped in rags, their heads caked with dirt, their eyes stuck together with pus and their legs all excoriated from the dirty diapers" (CS 159). In this emotionally straining environment—with suffering and pain as the focus of each day's work—the physician narrator possesses a seemingly harsh, cold outlook, which James Breslin describes as "clinical detachment" (Breslin 151). Brian Bremen further pins the sardonic doctor's behavior to a protective coping mechanism, claiming that "more than just a 'hard-boiled' submersion of feeling, the doctor's

refusal to feel empathy—to see himself in the other, or to see the other in himself—stems from a refusal to implicate himself in the world around him because of that world’s horror, treachery, and complexity” (Bremen 105). Williams’s doctor-narrator does often describe his patients in a brash manner and reduces the children to mere clinical specimens, as in the line “give it an enema, maybe it will get well and grow into a cheap prostitute or something” (CS 160). Use of the word “it” to refer to a patient, combined with the crude remark about the child’s future, illustrate his attempts at emotional distancing. Furthermore, the physician contrasts himself with the emotionally effusive nurses who “break their hearts over those kids,” as he claims that “I, for one, wish they’d never get well” and cuts himself off from any possibility of hope (CS 160).

When “little Jean Beicke,” arrives at the hospital, however, she sparks a slight change in the doctor’s outlook. (CS 160) As Breslin argues, Jean “awakens this doctor’s admiration and sympathy,” which is illustrated by his use of the diminutive modifier “little” before her name and his apparent fascination with her unusual features such as her straight look, long legged-body, and tenacious demeanor (Breslin 150). He admires endearing traits of Jean’s and enjoys her presence, as exemplified in the lines: “one thing that kept her from being a total loss was that she did eat. Boy! how that kid could eat!,” and “I had to laugh every time I looked at the brat.” As Jean’s stay at the hospital continues, he and his staff “all got to be crazy about Jean,” growing increasingly sympathetic towards the young girl in an emotional attachment that ultimately conflicts with the narrator’s attempts at maintaining a distant scientific mentality (CS 162).

The doctor continues to counter his fondness for Jean by viewing her in a detached, medically-based light. He characterizes the entirety of her time at the hospital by the stream of medical procedures and tests making up her treatment and attempts to focus solely on her symptoms rather than her personal traits. The story is full of medical language that illustrates

such attempts at objectivity. The narrator lists Jean's physical symptoms of a "stiff neck," "a fierce cough and a fairly high fever," and "inflamed eardrums" and uses medical terminology to describe his diagnostic and treatment ideas, as in the lines: "some thought of meningitis—perhaps infantile paralysis" and "we didn't want her to go through the night without at least a lumbar puncture" and "I made it out to be a case of bronchopneumonia with meningismus but no true involvement of the central nervous system" (*CS* 161). In many ways, these scientific details reduce Jean to an object to be examined, overriding any compassionate leanings and fulfilling what Breslin claims to be this physician's need to be "concerned with her only as a natural object" (Breslin 151). Once it becomes clear that "she was pretty sick," the doctor's need to distance himself becomes even more pressing. He even prepares himself for her death, taking a nonchalant, presuming stance and saying "we all expected her to die from exhaustion before she'd gone very far" (*CS* 162).

The conflict that "Jean Beicke's" doctor-narrator faces over the course of the story comes to a head when, despite he and his team's immense efforts to diagnose and treat her unknown condition, Jean dies. He initially explains his feelings on her death as frustration over his medical failings rather than sadness for her loss. After a long list of medical terms explaining end-of-life phenomena, the doctor bluntly states: "Anyhow, she died," illustrating his attempts to deceremonialize the occurrence (*CS* 163). As Paul Mariani states of these stories and of Williams's own views, "death was no tragedy for Williams, since for him the tragic was frankly out of the question for human beings. No, death was merely a biological matter" (Mariani 157). It is only directly prior to Jean's autopsy that the narrator, whom Hugh Crawford describes as "the brash, cold, but finally sympathetic pediatric ward resident," begins to describe his emotions, which he still qualifies with his gruff façade (Crawford *CCWCW* 182). The doctor

explains: “I hated to see that kid go. Everybody felt rotten. She was such a scrawny, misshapen, worthless piece of humanity that I had said many times that somebody ought to chuck her in the garbage chute—but after a month watching her suck up her milk and thrive on it—and to see those alert blue eyes in that face—well, it wasn’t pleasant” (CS 163). In this final assessment, the narrator admires Jean and mourns her death, but also shows continued clinical detachment that clashes with his emotions. The doctor’s description of the “rotten” grief and his hatred to see Jean die, combined with his brusque, almost obnoxious words about her potential fate, provide an explicit illustration of the struggle of balancing emotion and objectivity that pervades the patient interactions in Williams’s stories.

Unlike Jean Beicke—whose infant status prevents her from speaking to her doctors and thus results in a one-sided, physician-focused exchange—the vocal and opinionated woman in “Mind and Body” does verbally interact with her doctor, allowing the narrative to include the interpersonal elements of medical practice in its exploration of the emotional tensions that characterize physician-patient relations. The very title of this story points to the dialectic inherent in the physician’s job: balancing the emotional engagement required for treating the mental with the objective observation required for treating the physical. In fact, “mind” even comes first in the title, suggesting the importance of emotion and its power struggle with physical observation before the story even begins. The narrative structure also speaks to the tension between observation of physical symptoms and engagement in emotional interactions when treating a patient, as for the majority of the story the female patient merely talks at the doctor. Though the physician acts as the story’s first-person narrator and the work is structured as a dialogue, the woman patient’s is the main voice in the story, putting her thoughts and emotions at the forefront

of the medical process and pointing to verbal and emotional engagement's conflicting interplay with physical examination in medical proceedings.

The manner in which the patient uses her prominent voice extends the story's investigation of the emotion versus objectivity conflict. The woman is extremely frank, making straightforward statements such as: "I was an epileptic as a child. I know I am a manic-depressive" and "I don't care if I die. Nothing frightens me. But I am tired of dealing with fools" (CS 38, 39). The patient wants her doctor to exhibit similar blunt honesty, saying: "Tell me what you think" and "I simply want to know what is the matter with me. I have no inhibitions" (CS 39, 41). This frank openness has a two-sided significance in the doctor-patient interaction. On the one hand, such honesty is entirely objective. No pretenses of emotion or biases of personal thought cloud the exchange. However, the patient's straightforwardness could also be viewed as overly effusive, since failure to control the personal information revealed in the exchange grants emotion too much power. Thus, this story extends Williams's exploration of objectivity conflicting with emotion to question the very ways in which such elements interact.

A third story, "The Girl with a Pimple Face" shows emotional engagement conflicting with objectivity through the narrative trajectory itself, in which unchecked emotional reactions lead the doctor-narrator to alter his medical focus. When making a house-call to treat an ailing baby, the doctor is greeted by her older sister and is immediately attracted to her physical appearance, independent personality, and no-nonsense, self-assured attitude, saying: "Boy, she was tough and no kidding but I fell for her immediately" (CS 117). He pities her frustrating, yet easily treatable acne condition and allows his sympathy to control his outlook to the point that, as Breslin points out, he "is much more interested in this adolescent girl than in her baby sister, the one who he is sent out to examine" (Breslin 152). The adolescent's intrusion into the formal

diagnostic process brings outside sympathy and emotion into an otherwise pre-established protocol of care, starting a new and even ‘competing’ doctor-patient relationship that challenges the narrator’s professional objectivity and threatens to compromise his treatment plan.

Breslin offers a larger reading of Williams’s stories to argue that in their portrayed interactions between objectivity and emotion, the two elements not only conflict, but feed on and grow from each other. He returns to the story of Jean Beicke to explain that the doctor’s seemingly cold, neutral outlook actually gives him a unique ability to possess “an unsqueamish acceptance of *all* the facts about the child,” as his clinical observation takes him beyond knowledge of mere physical symptoms to open the door for an emotional understanding of the nonmedical side of her existence (Breslin 151). In “The Girl with a Pimple Face,” the narrator’s clinical viewpoint also enables his empathy. He focuses on the girl’s family as partners in care rather than extraneous side-parties in the medical exchange, and refuses to heed the critical remarks of fellow doctors who assert that the family’s mother “is the slickest customer you ever saw” and that the girl is a “pimple faced little bitch” (CS 129, 130). Such refusal demonstrates that “it is...the clinical viewpoint, its moral neutrality, that enables the doctor to become humanly involved” (Breslin 153). Furthermore by choosing to treat the needy, yet curable adolescent in addition to her baby sister, whom the narrator believes to be so ill that she is “no good, never would be,” he makes a practical decision that enables him ultimately to provide the most help (CS 124). Thus, as Breslin states, Williams’s stories of the doctor-patient exchange suggest a world in which “the impersonality of medicine opens the way to human sympathy” (Breslin 152). In this world, the clinical outlook actually brings a unique form of genuineness to feeling, allowing the observation-emotion interaction to be one of both conflict and harmony.

Williams's medically-focused poems also discuss the challenges of balancing objectivity and empathy in the doctor-patient exchange, with "Comfort" and "The Dead Baby" offering especially important examples. The short poem, "Comfort" details an instance of pure objective treatment from a doctor. In the first of the poem's six-lines of dialogue, the patient emphatically exclaims: "My head hurts like hell!," eliciting only a brief comment from the physician, who closes the poem by simply stating: "Here take these two aspirins" (*CP* 22). In this interaction, the patient dramatically and emotionally expresses a need, which the doctor objectively fulfills, providing an example of split perspectives—one emotional and the other objective—working together in an unbalanced exchange whose final outcome the poem leaves unrevealed.

In contrast to "Comfort's" straightforward brevity, "The Dead Baby" is a longer, more complex poem that explores the nature of grief and attempts at coping with it in the face of a child's death. Amidst descriptions of furious house-cleaning in preparation for an infant's funeral, the poem's speaker focuses on the parents' reactions. In fact, as Crawford points out, he skips over the death entirely and "leaves out the body, detailing instead the scene in the home" as he explores the challenges of controlling emotion under painful medical circumstances (Crawford *CCWCW* 185). The mother, who "sits/by the window, unconsolated" cries through eyes with "purple bags under them," while the "abler" yet still "pitiful" father sweeps the house over and over again as he attempts to cover his grief with action. This repeated action to "sweep the house" points out the cyclic, tireless nature of grief and shows the challenge of expressing the painful emotion, which is only alluded to in the poem as "it." Though grief is never mentioned by name, death itself is at the poem's forefront. The phrase "the baby is dead" is stated bluntly, with the word "dead" emphasized through the poem's only rhyme to show Williams's frank and direct treatment of the typically emotion-wrought situation. The poem further emphasizes the

dichotomy between objectivity and emotion when it states that the baby has gone “to heaven, blindly/by force of the facts,” asserting that death is an inevitable truth, forced upon the world and impossible to cover up, even with the “fresh flowers” that surround the baby upon its return from the hospital (*CPI* 268).

The dichotomy between objectivity and empathy explored in the medical narratives is a challenge that Williams himself—as both a physician in his regular medical practice and as a patient later in life—faced on a daily basis. In a statement from an unpublished essay reflecting on his short stories, Williams directly links himself with his physician narrators when he explains that in writing a story “you’ve got to BE the persons interchangeably, AND at the same time the narrator,” thus aligning Williams’s experiences with those in his stories and allowing for extrapolation from his narrators’ perspectives on the observation-empathy conflict to his own (“Prose” Beinecke 2). For example, likening himself to his doctor narrators, Williams describes the significance of observation in his daily routine, stating: “I go in one house and out of another, practicing my illicit trade of smelling, hearing, touching, tasting, weighing” (quoted in Mariani 157). Though these sensory-based observations formed the backbone of his practice, Williams also frequently experienced the power of emotion in his medical encounters. In a letter to Parker Tyler in 1946, he recounts a particularly emotionally trying medical experience, about which he says: “the loneliest thing I have seen in months was, last night, a five-months-old fetus lying in the bottom of an enamel dishpan among its impedimenta of muck and afterbirth...I was sick to my stomach from a case of intestinal grippe at the time,” as he wrestles with sympathy, pain, and acceptance of death even under the professional outlook of a physician (*SL* 244).

A more specific manifestation of the observation verses emotion conflict that Williams cites in his own life concerns the limits of the doctor’s objectifying gaze. Bremen explains that

while Williams recognized studying patients on an objective level as a vital step in treatment, he feared that observation alone reduced the patient from his or her full complexity and hindered proper diagnosis. Bremen claims that in Williams's works, strict objectification can become dangerous "when it takes the form of the clinical detachment shown toward the body in an act of diagnosis," while on the other hand, an "*empathetic* act of diagnosis that does not attempt to reduce or punish the body is essential to Williams's idea of 'cure,'" as he highlights the necessity of balancing empathy and observation (Bremen 118).

After suffering a heart attack in 1948 and a series of strokes in the years following, Williams gained a new perspective on the doctor-patient exchange that gave him further insight into the emotional side of a patient's world. The symptoms following his stroke, especially, caused Williams longstanding problems. Mariani points out that these symptoms did not stop at double-vision and shaky hands, as Williams also suffered emotional turmoil in the form of "a depression that sapped Williams of all desire to work," providing him with an enlightening experience of the mental side of physical health (Mariani 646). In fact, following Williams's second stroke in 1952, his depression was so severe that in February 1953 he was admitted to Hillside Hospital in Queens, NY, on a stay that produced such poems as "The Cure" and "The Mental Hospital Garden" (Mariani 659). Williams's developing appreciation for the emotional side of medicine during the course of his illnesses comes through in a June 1952 letter to David McDowell, when he expresses his longing for a cure and asserts that "its hard for me to be patient, and its now that I need it. One day it goes well but my eyes suddenly jump out of focus and with that my mind goes also," illustrating the connection of mental morale with physical progress towards rehabilitation. Williams writes again to McDowell and says that "this has been one hell of an illness, this nervous instability. I hope you are spared it forever and a day,"

revealing his expanding perspective on suffering and adding to the power of empathy in the doctor-patient exchange to further the double-necessity of emotion and observation (*SL* 314).

While empathy is certainly one of the most powerful emotions that Williams's narrators face in his stories' discussion of the medical experience, his doctors also cope with countless other personal emotional reactions as they interact with their patients. Anger, confusion, sexual attraction, pride, frustration, curiosity, and excitement all interfere with these doctor-narrators' intended objectivity. In his stories and poems, Williams extends his discussion of the objectivity versus emotion conflict to examine the ways in which his doctors manage these other responses as they try to maintain a professional, medically-appropriate relationship with their patients.

Williams's most widely-read and debated story, "The Use of Force," which Bremen describes as "a near-standard text in the field of literature and medicine," offers his most dramatic account of a doctor's struggle to control his emotions when dealing with a challenging patient (Bremen 87). When the narrator arrives at the home of a young girl whom he has been called to examine, he finds himself caught up in a battle of wills with the terrified, obstinate child who refuses contact of any sort, and whose parents' unhelpful presence only exacerbates the conflict. Throughout this trying encounter, the doctor must work to put on a calm, collected façade, and his difficulty suppressing the powerful emotions that ultimately overcome him demonstrates the challenge of maintaining professionalism under the power of emotion.

Harbingers of the appointment's struggles appear from the moment the narrator arrives at the house, as the mother greets him and leads him to the back room where her daughter and husband—whom he notices to be "very nervous, eyeing me up and down distrustfully"—are waiting (*CS* 131). Despite the uncomfortable introduction, the doctor starts by attempting an objective evaluation of the child's status. As Bremen explains, "Williams at least begins his

diagnostic procedure in a way that both adheres to accepted principles and demonstrates the shrewd superiority of the general practitioner” (Bremen 101). The physician notes that the girl’s “face was flushed, she was breathing rapidly, and I realized that she had a high fever,” and combines this observation with information from the father and his own knowledge of a recent diphtheria outbreak to conclude that he needs to examine her throat (CS 131). It is here that the trouble begins: the route of a simple diagnosis based on objective assessment of symptoms becomes impossible when the child refuses to open her mouth for examination. Though the doctor coaxes her kindly, the child’s continued stubbornness combined with her parents’ well-intentioned, yet hindering attempts at encouragement prevent examination and cause enormous frustration. The doctor attempts to conceal his exasperation, explaining that instead of revealing his anger, “I smiled in my best professional manner” when addressing the girl and “ground my teeth in disgust” as to “not allow myself to be hurried or disturbed” by her challenging parents (CS 132).

The doctor’s mounting frustration as the exchange continues forces him to resort to even more powerful means of restraining his emotions. For example, when his next attempt at a throat culture results in a physically violent outburst from the child, who “clawed instinctively for my eyes” and “knocked my glasses flying,” he loses his ability to keep a calm demeanor and turns to honesty and bluntness to maintain his objective position (CS 132). After the parents tell their daughter to behave for the “nice man,” he candidly declares, “don’t call me a nice man to her. I’m here to look at her throat on the chance that she might have diphtheria and possibly die of it.” He also presents the child herself with the reality of the situation, saying “we’re going to look at your throat. You’re old enough to understand what I’m saying,” as he treats the young patient with the same straightforwardness he showed to the parents (CS 133).

Soon, even a turn to blunt honesty fails to contain the doctor's rising anger in a moment when personal emotion and professional objectivity reach full incompatibility. When the girl's father tries in vain to restrain her for a second attempt at a throat culture, the doctor becomes so frustrated that he "wanted to kill him" as the physician's anger finally conflicts uncontrollably with his professional aims in a moment of madness that drives the rest of the story (*CS* 133). Donohoe blames the parent's difficult demeanors for so dramatically aggravating the physician's emotions, asserting that the doctor-narrator's "antipathy was directed primarily at the child's parents, whose passive unhelpfulness thwarted his early efforts at obtaining the throat culture" (Donohoe 14). However, the physician's anger escalates far beyond irritation with the parents. He explains that "I also had grown furious—at a child...I tried to hold myself down but I couldn't" (*CS* 134). In his final assault on the impossible patient, he admits, "it was a pleasure to attack her. My face was burning with it" as "a blind fury" overcomes him (*CS* 134, 135). Donohoe describes the narrator's reaction as "a violent attack," and the physician himself refers to his explosive emotion as "a final unreasoning assault," admitting his total loss of logic and control (Donohoe 14, *CS* 135).

This aggressive treatment of the young girl provides a troubling description of the dangerous possibilities in the charged doctor-patient exchange, which Monteiro links to the emotion versus professional objectivity conflict when he comments: "Fury at a child, in an adult, is ugly enough. Fury at a child who is also a patient, in a doctor, is, of course, professionally inexcusable" (Monteiro 78). Monteiro further argues that because "the narrator allows his own emotions precedence over professionalism," "Williams's account of the doctor's impetuous and dogged struggle with his young patient renders brilliantly the fragility of that professional's affective neutrality by which the physician would do his life's work" (Monteiro 79). Donohoe,

too, recognizes the damaging effects of the emotion-objectivity clash and sees the story as a commentary on the challenges of emotion in the medical profession. He claims that in this story, Williams “illustrates the tragic irony that doctors, despite spending many years learning to care, may, in a moment of frustration, release pent-up anger upon their patients” (Donohoe 14).

The conflict between “The Use of Force’s” doctor-narrator’s personal reactions and professional intentions manifest themselves in ways beyond his inability to cope with anger. Another emotion that conflicts with his intended clinical objectivity is his admiration and fascination with the child patient. Here, the doctor’s observation of the girl’s body for medical reasons intertwines with a personal assessment of her physique and demeanor, marking a tense border between the objective and the personal. When he first sees the young girl, he describes her as “an unusually attractive little thing, as strong as a heifer in appearance,” and also points out that “she had magnificent blonde hair” and was like “one of those picture children often reproduced in advertising leaflets and the photogravure sections of the Sunday papers” (CS 131). The first of these two descriptions, citing her physical hardiness, could be a medical appraisal in which the doctor studies her build as an indicator of health. Breslin furthers this point, arguing that the doctor does not admire the girl “because she is beautiful...but because she reveals a certain force of character” (Breslin 155).

On the other hand, the doctor’s continued admiration of her magazine-cover appearance leads other commentators to question his outlook: is the doctor really noting her appearance in comparison to other children he has treated, or is he allowing sexual feelings to make their way into the exchange? As a number of critics, including Marjorie Perloff, argue, the doctor’s final attack on the child can be seen as a rape, in which his rising anger is actually misplaced sexual energy that leads him to “penetrate” her in the attempt at a throat culture that leads to his

personal gratification. R.F. Dietrich declares that in this story, “the connotations of rape are unmistakable.” He asserts that “the girl is ‘overpowered’ as the physician forces the spoon down her throat, thus exposing the ‘membrane’ that is her secret,” likening her disease to her virginity and the doctor’s violent diagnostic procedures to an act of violation (Dietrich 450). Perloff brings another element to this claim when she argues that the physician’s satisfaction in his defeat of the child “induces a sense of elation or victory that seems quite in excess of the actual event,” noting “the subliminal erotic response” that the physician has for his young patient (Perloff 841). From this perspective, the doctor’s admiration for the girl, and his statements such as “I had already fallen in love with the savage brat,” are sexual (CS 133).

However, other elements in the story—such as the parents’ participation in the event despite the doctor’s contempt, and especially the fact that the doctor’s motivations for the diagnosis move beyond personal satisfaction to include saving both the girl and her peers from an infectious disease—point to a different reading, in which professional tensions cause the doctor’s human emotions to conflict with his desire to do his job. After all, the narrator continues his “assault” and refuses to leave the exam until later because he has “seen at least two children lying dead in bed of neglect in such cases.” He tells himself “that I must get a diagnosis now or never” in order to save the girl and do his duty to the community (CS 134). As Donohoe explains, the doctor “knew that a throat culture was vital to diagnose the child,” arguing that the physician’s actions are professionally motivated, however complicated by emotion such motivations may be (Donohoe 14). Dietrich also admits the validity of this reading in the face of his previously described argument for rape when he acknowledges that “the sexual connotations are there because they express the savagery in human nature, that, lying so close to the surface, can erupt at any moment in a flow of irrational behavior, especially...when primitive force is

required to achieve some civilized end,” recognizing the emotional and moral conundrum of the encounter (Dietrich 450). Crawford, too, argues for a combination of both the rape and professional-tension based readings. He agrees with Donohoe that “the doctor asserts medicine’s altruistic, if somewhat patriarchal, motives” but he also believes that this doctor’s “justification is weakened by his admission of his own ‘blind fury,’” as “the argument that it is all for the child’s own good rings false in the face of his overwhelming lust” (Crawford *MMWCW* 80).

A final element of “The Use of Force” that explores the challenge of professionalism is the dramatic contrast and dynamic interplay between the doctor’s and his child patient’s behavioral standards. Though the doctor must maintain a professional status in order to treat the child and fulfill his responsibility to protect the community, the young girl has no need to contain her feelings. She shows no emotional inhibitions, constantly screaming, giving commands, and even lashing out violently. The narrator describes how “she shrieked terrifyingly, hysterically,” and marvels at the “magnificent heights of insane fury” that she makes no attempt to hide (*CS* 134, 133). The child’s eruptive emotional displays feed the doctor’s own frustration—as her terror mounts, so does his determination. As she screams in “wild hysterical shrieks,” the doctor is spurred onward, experiencing a “longing for muscular release” that ultimately leads him to “attack” (*CS* 134, 135). This back-and-forth exchange of mounting passion is portrayed as a true battle, characterized by words like “operatives,” “defensive,” and “defeat,” a view that James Breslin confirms when he refers to this story as “a fierce and humiliating contest between adult and child” (*CS* 135, Breslin 155). In such a contest, the doctor feels that he must rise to the level of his opponent—leaving behind his professional objectivity to achieve diagnostic triumph.

Another story, “A Face of Stone,” tells of its doctor-narrator’s developing relationship with two parents of a sick baby as it explores the challenges of separating internal emotions from

external behavior in the physician's attempts to maintain objectivity. Terrified, confused, and ignorant of the complexities of proper medical protocol, the parents in the story place high demands on their child's doctor, causing immense frustration that he must work to repress in order to properly treat his patient. Throughout the narrative, this opinionated physician points out specific moments where he hides his harsh inner feelings and, instead, takes more professional actions. For example, as he lists the couple's various traits—such as their impoverished status, displeasing physical appearances, and foreign ethnicity—and expresses irritation with their poor communication skills and late-night phone calls, his dislike becomes obvious. He disapproves of their filth, saying they “looked dirty” with “that usual smell of sweat and dirt you find among any people who habitually do not wash or bathe,” and further highlights his contempt when he labels them “just dumb oxen...Half idiots at best” (CS 167). However, the doctor keeps all of these judgments to himself, as in the lines: “People like that belong in clinics, I thought to myself” and “to hell with you, I thought to myself” (CS 167, 168). Four months later, when the parents return to his office with their baby, he wants to refuse to see the family that so frustrates him. When they enter his exam room, uninvited, however, he continues to keep his frustration inside. Though he thinks to himself “good night! That finishes me for the afternoon,” he actually says “all right, put it up on the table” and proceeds to examine the baby (CS 170).

As the visit proceeds and the parents continue to demand that the doctor complete more exams to further study their baby's symptoms, he grows increasingly irritated until he finally loses the ability to conceal his emotions, so that “the blood went to my face in anger.” With this growing fear of revealing his inner feelings, the doctor must look to a new method to mitigate the conflict between his internal emotions and professional obligations. Ultimately, he returns to a hyper-focus on the objective, zeroing in on sensory-based observation to distract from emotion

and move towards diagnosis. He explains that “to quiet my nerves I took my stethoscope and went rapidly over the child’s chest,” as he stifles his feelings via an objectivity-based ritual that highlights the power of detached medical procedure to counter emotion (*CS* 172).

In a final story, “Danse Pseudomacabre,” Williams describes a physician’s turn to objectivity in the face of emotional strain from all angles: as a coping mechanism for managing troubling situations such as death and illness, as a means of keeping the self calm in the face of another’s distress, and mostly, as a means of ensuring effective diagnosis. Throughout the story, the doctor-narrator normalizes typically troubling events. For him, a patient’s failing health, emergency house calls, and even death, are all insignificant occurrences. The narrator explicitly states his philosophy of “that which is possible is inevitable” and “I defend the normality of every distortion to which the flesh is susceptible,” demonstrating a major means of coping with emotion: reducing of all phenomena to fact and learning to expect all outcomes (*CS* 208).

In this story, the narrator’s methods of detachment and preparedness in controlling emotion are tested when he gets a house call in the middle of the night. In keeping with his indifferent outlook, he is “unsurprised, almost uninterested” in this nighttime emergency, which he recognizes as expected protocol of medical care. After receiving this call, however, the doctor faces a telling moment of emotional stress when he looks at his wife and reflects on death, musing “how can I ever bear to be separated from this my boon companion, to be annihilated, to have her annihilated? How can a man live in the face of this daily uncertainty?” (*CS* 208). Here, his emotions rise to display the internal feelings that must be subdued in his attempts at objectivity.

When the doctor arrives at his patient’s house, the wife’s extreme anxiety poses a challenge for his calmness. She yells “hurry, hurry, hurry! Upstairs! He’s Dying! Oh my God!

my God, what will I do without him? I won't live!" as she displays an expressive outburst that parallels the doctor's own earlier briefly surfaced fears. The doctor responds by emphasizing the importance of emotional restraint, stating: "Kindly be quiet, madam. What sort of way is that to talk in a sickroom? Do you want to kill him?" He then proceeds with his objective treatment by studying the patient's body and observing his physical symptoms while calmly answering the wife's questions. He even gives the wife specific advice, telling her: "Follow these instructions. I have written down what you are to do," showing his straightforwardness in both diagnosis and treatment (*CS* 209). Later in the story, the doctor faces a second patient encounter in which he continues to exhibit his calm demeanor and blunt response to medical phenomena. Here, he is called to treat a fatally ill infant and immediately reveals his frank outlook when he responds to the mother's asking "will it live" with the harsh, yet straightforward answer of "if it lives it will be an idiot perhaps. Or it will be paralyzed—or both. It is better for it to die" (*CS* 210).

The doctor's objectivity in his diagnostic procedures is central to this story, as he avoids emotional bias and focuses solely on sensory, physical details when diagnosing his patients. When treating the sick baby in the second part of the story, for example, he lists the observations that lead him to diagnosis: "The lips are blue. The mouth puckers...The body slowly grows rigid and begins to fold itself like a flower folding again. The left eye opens slowly, the eyeball is turned so the pupil is lost in the angle of the nose...Meningitis. Acute" (*CS* 210). With this emphasis on observation combined with his unapologetic honesty, the doctor shows clinical detachment similar to that in "Jean Beicke" as he keeps a distant and almost fatalistic outlook to prevent emotion from conflicting with professionalism. This story also points to another role of objectivity in the medical exchange: protection of the patient. Though a detached, scientific view on death and illness guards the doctor from the emotional turmoil that could result from frequent

exposure to such tragedies, it also enables him to prepare his clients for these difficult, often inevitable outcomes and make their exchange slightly more free of fear and uncertainty.

A number of the physician-patient exchanges in Williams's poetry also explore instances in which the doctor must contain his personal reactions to mitigate the conflict between emotion and objectivity. The most controversial of these dramas comes during the exchange between doctor and rape victim in *Paterson III*. In this interaction, Doc Paterson faces a range of conflicting emotions—such as rage, tenderness, admiration, and sexual attraction—which threaten any chance of neutrality. During the poem's first description of the exchange, the physician enters the house of the woman whom he has dubbed "the Beautiful Thing." This dark, mysterious female figure, who embodies both beauty and brutality, serves as one of the central symbols of creation bred from destruction that runs through the larger *Paterson* narrative. Her experience of cruel rape combined with her transcendental beauty parallel her with the poem's other instances of violence, a motif that comes to a head in the work's third book. The fact that during the doctor-patient exchange, this "Beautiful Thing" lies in the basement of a building speaks to Doc Paterson's use of her beauty and suffering as a symbol in his search for a buried power to bring his world renewal. However, Paterson's excitement over this woman's potential power clouds his medical perspective. Erin Templeton draws on this emphasis on the woman's beauty and the physician-poet's attempt to objectify it when she argues that before the exchange even begins, Doc Paterson already struggles with his ability to practice clinical neutrality. She cites Sandra Gilbert and Susan Gubar in their claim that his "use of the term 'thing'...lacks sensitivity, objectifies and further victimizes the assaulted woman," showing how, here, his attitude crosses the line between detachment and dehumanization (quoted in Templeton 107).

Immediately upon meeting the woman, the doctor is overwhelmed with passionate anger and desire. He orders her: "Take off your clothes,.../Your clothes (I said) quickly, while/your beauty is attainable." Paterson also explains that he spoke "in a fury, for which I am/ashamed," recognizing the problems inherent in his speech's betrayal of his feelings. With rising anger, he repeats his orders: "TAKE OFF YOUR/CLOTHES! I didn't ask you/to take off your skin. I said your/clothes, your clothes," as his repetition of lines and the use of capital letters highlights his fury. He even insults the woman, telling her "you smell as though you need a bath" and "you smell/like a whore" and remarks, "I ask you to bathe in my/opinions" showing his irritated judgment and inability to contain his thoughts under passion's influence (*Paterson* 105-106).

The physician's continued interactions with the assaulted woman show increasingly conflicted emotions, as tenderness and admiration make their way into the already charged exchange. When the doctor approaches his female patient, who is "(alone in the house)/ lying there, ill," he is overcome by sympathy for the figure who is "by the wall on [her] damp bed, [her] long/body stretched out negligently on the dirty sheet." Though he momentarily follows conventional objective treatment measures, observing the patient's body and asking her "where is the pain?" he is ultimately "overcome/by amazement," explaining that he "could do nothing but admire/and lean to care for you in your quietness" (*Paterson* 125, 126). The two parties merely stare at each other in silence, showing the impossibility of effective communication that arises when emotion mars the exchange. The physician reveals the influence of his emotions when he admits that he was "shaken by your beauty/Shaken by your beauty./Shaken," as his repetitive language demonstrates the all-encompassing nature of his feelings (*Paterson* 126). In fact, elsewhere in the long poem, Williams's narrator articulates that "vulgarity surpasses all perfections," and explains that he sees the "Beautiful Thing/—intertwined with the fire," linking

his female patient with burning passion and expressing his view that ‘vulgarity,’ or unrefined emotion, will always defeat the ‘perfections’ of objectivity (*Paterson* 120). Templeton supports this reading when she quotes Louis Martz’s claim that “the Beautiful Thing then is not the girl in herself but it is the human response, the fire of the imagination, the fire of human affection” as she suggests that emotional passion is intrinsic to mere interaction with the patient (quoted in Templeton 107).

This emotion-wrought exchange between Williams’s physician and his female patient has been the subject of much debate and has sparked various readings on the physician’s treatment of the woman. Many criticize his harsh aggression, especially its sexual connotations. Crawford, for instance, argues that the domineering power of the doctor’s gaze—which is complicated by his inability to contain his emotions—directly impacts the patient’s own outlook and behavior. He claims that “‘masculine’ science’s primary tool is the gaze—the penetration by an actor (usually male) of a passive (usually female) figure,” thus affirming the power-dynamic between the doctor and the woman. As Paterson places his emotion-wrought and violent gaze on his patient, he creates a “situation where...the woman, or the patient *want* to be looked at,” suggesting that the physician’s uninhibited emotions and oppressive treatment force the patient into submission (Crawford *MMWCW* 68, 70). Breslin similarly argues that the two parties’ emotions interact, though he reaches a different conclusion. His main claim is that the emotions of the patient and physician have a mutual and cyclic influence over each other, highlighting the two-sided delicacy of the doctor-patient exchange. This interplay becomes problematic in *Paterson III* when the doctor allows himself to feel the submissive pain of his raped patient, as “she accepts her brutal treatment fatalistically, and so now does Paterson” (Breslin 190). Thus, the doctor, too, becomes trapped in his patient’s suffering, which contributes to his objectivity-clouding

affection. Despite their differences, Crawford and Breslin's arguments both point to the central problem of maintaining self-control in the face of unchecked emotion, which Doc Paterson must confront in his larger quest for solutions to the violent contemporary world of the poem.

Some of Williams's shorter poems also explore the conflicting roles of personal emotion and objectivity in the medical world. His early poem, "Hic Jacet," describes the merriment of a coroner's children, who exhibit constant joy despite the grim nature of their parent's world. These children "laugh because they prosper" and "jibe at loss, for/Kind heaven fills their little paunches" (*CPI* 15). For them, like the doctor in "Danse Pseudomacabre," death is not sad, but is an expected, normalized event. In fact, death actually provides the income that allows their family to flourish. Christopher MacGowan points out that this poem is "the result of [Williams's] careful observation and his medical work in the local community," paralleling a practicing physician's objective perspective on medical symptoms with the children's neutral outlook on death (MacGowan 3). The events in "Complaint" more specifically link to the medical realm, as they illustrate the emotions of a doctor when he embarks on a house call, driving along "a frozen road/past midnight" to reach his patient. In this poem's medical exchange, the doctor demonstrates both compassion and objectivity, beginning with his ability to "smile" as he enters the door and then immediately transition to objectively observing his patient, "a great woman/on her side in the bed" whom he notices "is sick,/perhaps vomiting,/ perhaps laboring." When delivering his patient's child, the doctor further allows emotion to enter into the exchange as he explains, "I pick the faint hair from her eyes/and watch her misery/with compassion," highlighting the tenderness of their interaction (*CPI* 153). As Milton Cohen explains, despite the physician narrator's "unvoiced complaint about having to get up and go out into the freezing night to answer this call," the poem is pervaded by "compassion for this woman's suffering,"

demonstrating the complex emotions that the physician effectively balances as he performs his job (Cohen 67).

The interplay between objectivity and emotion in his portrayals of the medical experience also shows in the basic elements of Williams's writing style and views on literature—continuing the parallel between his medical and literary worlds and demonstrating the pervasiveness of the objectivity versus emotion conflict. On the one hand, Williams's views on the distinctions between prose and poetry parallel his arguments for the distinction between the roles of observation and emotion in medicine. Williams saw the short story as “the best form of the ‘slice of life’ incident,” excellent for portraying the tiny happenings he noticed in the world around him (*SE* 297). In this reality-based prose, he emphasized a clarity and cleanliness similar to the objectivity of the physician. As Alec Marsh states, Williams ensured that his prose was “accurately adjusted to the exposition of facts” and wanted to “keep the stories as close to the actual as possible, not with self-conscious avant-garde tricks, but through a plain rendition of the moment” (Marsh 89, 90). Breslin also stresses Williams's focus on reality over creative innovation in his prose, arguing that prose “allowed Williams to deal with a kind of ordinary social and human reality missing from the intense, experimental work of the 1920s” and further links it to his medical career by claiming that in prose, “he could explore the material gathered in his daily experiences as a doctor” (Breslin 126).

Unlike his prose, Williams treated poetry as a place for experimentation. His poems contain more emotional expression and material stemming from his internal experiences than do his prose narratives. In fact, Williams himself explains that poetry takes the “reality of words” and uses them creatively and contemporarily, demonstrating his poetry's separation from the real-world focus of his prose in its favor of creativity (*EK* 144). Williams also explains in his

essays that while sensory observation is valuable to poetry, the role of imagination is paramount. He claims of his poetry that “the thing that stands eternally in the way of really good writing is...the virtual impossibility of lifting to the imagination those things which lie under the direct scrutiny of the senses, close to the nose” (*SE* 11). In this quotation, Williams explains that reliance on sensory observation alone, which is a fundamental element of his prose works and of medicine, actually provides a major barrier for poetry. Finally, their differing narrative techniques provide another contrast between the objective reality of his prose and his more experimental poetry. Though still autobiographical in nature, the prose narrators in Williams’s medical stories are typically fictional doctors providing first-person, journalistic accounts of their encounters with patients, while the poems’ speaker is always Williams himself, highlighting his distinction between the levels of personal engagement in the two genres and recalling the parallel conflicts of communication faced by the writer and doctor as they interact with their respective populations. In the poetry, with Williams as the narrator, the problem of audience connection is between the reader and the poem’s speaker, and thus the writer himself, while in the physician-narrated prose, this communication struggle is transposed onto the fictional doctor and his patient.

Despite the stylistic differences between Williams’s prose and poetry and the complex views on the observation versus emotion conflict that his works exhibit, all of his writings reveal a similar outlook on the nature of objectivity’s relationship with feeling. These works affirm the value of both elements while also noting the dynamic nature of their interplay and its inherent conflicts. Cohen summarizes this relationship when he claims: “Williams’s fiction... reflects the same political qualities as his poetry: precise observation, empathy for ordinary, working-class people,” as the two conflicting elements exist side-by-side (Cohen 76).

While the conflict between observational objectivity and emotional engagement in Williams's accounts of medical interactions stems mainly from factors isolated to the doctor-patient exchange itself, the second overarching conflict that Williams explores—that between the scientific and interpersonal sides of medicine—stems from sweeping changes in medical practice and in society at large. One of the manifestations of this conflict is in the distinction between a strictly physical-symptom-based approach and a more holistic method that looks beyond clinical tests to also treat the mental and social side of disease. In this conflict between the consideration of physical versus mental health, the physician's attention to psychology and interpersonal relations in the diagnostic process clashes with the medical community's increasing deference to scientific authority.

In "The Insane," Williams's autobiographically-based characters address this conflict when they engage in an ideological discussion that reveals their belief in addressing mental and emotional factors of disease in addition to treating physical symptoms—despite frequent disagreement from their fellow doctors. The pair of physicians in this story—an older doctor speaking to his medical-student son—likely represents Williams and his oldest child, William Eric, again linking the views of the story's characters with Williams's own opinions on the changing medical world. One of the story's first lines points to the importance of holistic medicine, as when the son tells his father about his psychiatry unit in medical school, the older man responds: "Psychiatry, eh? That's one you won't regret" (CS 287). The son even cites a specific case that illustrates the value of incorporating psychology into treatment alongside the more scientific, physical observation-based methods. This example involves a violent little boy whose frequent misbehavior combines with troubling physical symptoms in a mysterious case that seems to resist cure. However, when the young man and his fellow doctors look to the boy's

patient history for further clues, it reveals traumatizing events in the boy's life, such as his fathers' death and ensuing mistreatment by his mother, that correlate with his behavioral struggles. With this unfortunate history in mind, the doctors are able to use psychology to explain the boy's weight loss, constipation, and emotional distress to arrive at a well-rounded diagnosis and treat him so that "the outcome is supposed to be quite favorable" (CS 290).

As Bremen explains, "the son's point in the story is this: the boy's psychological case history yields a far more significant diagnosis than any physical examination." Bremen demonstrates Williams's common assertion in his stories that "limiting a diagnosis to a reading of the physical signs of disease ignores those psychological and cultural symptoms that extend the notions of sickness and cure beyond the physical realm of the body" (Bremen 103, 85). Many of this short story's other physicians do not share Williams's and his narrator's valuing of the more well-rounded, less scientifically-based side of medicine. The son tells his father that when discussing psychological elements with other members of his hospital team, they respond: "Oh those are just the psychiatric findings," angering the young man who disagrees with their solely scientific focus and explains that such a response "gripes me" because, after all, "it's the child's life!" (CS 290). For this doctor, and for Bremen, focusing on science is not enough, as "the child's life"—the case history—cannot be reduced to...the diagnosis obtained from just the physical examination," as "both disease and cure lie outside that space, in the psychological and the verbal" (Bremen 103).

Revisiting the story "Mind and Body" allows for a study of its narrator's attempts to navigate the mental-physical link in medicine, as he engages both approaches in his diagnostic and treatment procedures. His vocal female patient herself reveals the problems that arise when doctors look to science alone in carrying out their diagnosis when she complains about previous

physicians who looked only to physical elements of disease and refused to trust her statements. She asks: “How can they say it is my imagination? They don’t know. They’re fools” (CS 38). Unlike her previous physicians, however, the story’s narrator does attend to the woman patient’s needs, considering her personal history and taking her assertions into account as he demonstrates the importance of listening in the medical treatment process.

Demonstrating the continuous interplay between this valuable, psychology-based tool of listening and the opposing scientific side of medicine, the doctor also studies the patient’s body to complete his examination. Despite her reported symptoms of stomach pain and a cramping heart, her physicality proves to be normal, as “she looked clear-eyed, her complexion was ruddy, her skin smooth. Her bearing was alert, her movements perhaps too quick but not pathological” (CS 41). This absence of traditional indicators of pathology despite the patient’s obvious distress shows that the body itself does not always tell the whole story. Bremen asserts that Williams’s own medical experiences, along with the philosophies of various medical scholars cited in his discussion, indicate that a person is both a “physiological body” and a human being with experiences, thoughts, and feelings, thus requiring both physical and psychological examination (Bremen 103). The doctor continues to show this dual focus when he gives his diagnosis in terms of both mental and physical factors. He explains to his patient: “From what you say, and the length of time the symptoms have been going on, the fact that you have not lost weight, that you are ruddy and well, I believe that you are suffering from...mucous colitis...a spasm of the large intestine.” The physician even states, “there has never been an anatomic basis discovered for an opinion in cases like yours...until recently,” showing that anatomy cannot always explain disease, and that both science and psychology are required for effective treatment (CS 48).

In addition to discussing the dynamic, often antagonistic interaction between the psychological elements of treatment and the more observation-based approach of focusing on physical symptoms, many of Williams's stories illustrate a second, even more significant implementation of the scientific vs. holistic medicine conflict: that between the personal, intuitive methods of traditional practice and the more technical, laboratory based procedures of modern medicine. In these 'science stories,' Williams's physician-narrators highlight the challenges of patient treatment in a time of technical transition and scientific advancement, demonstrating the conflict between 'new' and 'old' styles of medicine. Within this tension, the intuitive knowledge of the doctor conflicts with increasingly strict demands of protocol, as well as with the power of newly invented treatment methods that bring medicine out of the interpersonal home environment and into the modern world's exclusively scientific realm.

In *Modernism, Medicine, and William Carlos Williams*, Crawford examines the intricate relationship between 20th century technological advancements and contemporary developments in medical education, methods, and discourse that characterized Williams's era of practice and also influenced his writing. As Crawford points out, under the era's "new medicine," "medical education and practice were becoming increasingly scientific" (Crawford *MMWCW* 5). Medicine was becoming more firmly based in the laboratory and hospital, and focused on test results, pathology, and medication rather than on the interpersonal side of patient care. Such changes drastically impacted family physicians, such as Williams and his narrators, whose local practices consisted largely of house calls and were based on longstanding personal relationships. Crawford summarizes the changes in this "increasingly scientific" medical world and describes their impact on local physicians such as Williams when he states that "hospitals and the AMA were discouraging the house-calls that had provided Williams with his all-important contact, and

medical professionals were becoming more aloof and separated from the lives of their patients” (Crawford *MMWCW* 150). As Williams’s parallel aims to connect with his audience in his poetry and to form positive relationship with his patients shows, he would resist such separation.

Some of the innovations that most contributed to this distance-inducing change in patient care include the microscope and stethoscope, both of which allowed the physician to investigate symptoms independently of patient input or involvement. Crawford argues that under such tools—which separate the patient from the symptoms in question and “are nearly always machines designed to bring the body under the gaze of the physician”—patients become not people in need of healing, but inhuman “veil[s] hiding the truth of disease” (Crawford *MMWCW* 91, 71). Further changes in medicine include the rise of the hospital, which was “transformed... to a haven of cleanliness and up-to-date, efficient, healthcare,” focused on proficient treatment and scientific procedure rather than on the patients’ individual needs and perspectives (Crawford *MMWCW* 85). Even the rising use of the car and telephone put efficiency and practicality at the forefront of medical practice by altering means of communication, shifting the location of care, and increasing speed of and access to treatment facilities. In fact, many of Williams’s poems and stories, such as the first poem in *Spring and All* (“On the road to the contagious hospital”) and “Complaint,” place the narrator inside a car as they illustrate the widespread changes at this time of professional transition (Crawford *MMWCW* 89).

In his discussion of the rise of scientific medicine, Crawford often asserts the importance of mixing the new practice with the old, enforcing a unity of the two worlds that he sees as crucial for Williams’s physicians. He argues the value of the old-style, patient-centered medicine when he claims, “regardless of technological innovations, patient confession remains an integral part of the unveiling of disease” but also recognizes its interplay with new methods by asserting

that “in medicine, knowledge is produced at the patient’s bedside, in the laboratory, or in the hospital ward” (Crawford *MMWCW* 77, 46).

Williams’s story “A Night in June” provides an excellent example of the conflicts a physician faces when navigating the boundary between the elements of past and present medicine, or, as Monteiro asserts, “between Science and Humanity” (Monteiro 81). In this story, the doctor narrator helps a pregnant woman—one of his regular patients whose other children he had delivered in years past—labor under extremely challenging birthing conditions in a narrative that Crawford describes as “a complex meditation on the relationship of technoscience...and childbirth” (Crawford *MMWCW* 101). The medical exchange in this story takes the form of a house call—the iconic image of old-style medicine—which provides both doctor and patient the comfort and personal convenience of home, yet lacks the cleanliness and modern surgical materials necessary for the most effective treatment. Though Crawford argues that the story’s home-birth celebrates the emotional and social connection between doctor and patient and that it “laments the accelerated pace of a technology driven practice,” the benefits of the hospital and its improved scientific technology pervade the text (Crawford *CCWCW* 177). The physician-narrator himself explains: “One gets not to deliver women at home nowadays. The hospital is the place for it. The equipment is far better,” as he recognizes the benefits of new medicine and reveals nostalgia for the practices of old, beginning the back and forth engagement of the two medical styles that runs throughout the narrative (*CS* 137).

The details concerning the doctor’s preparation for this house call illustrate the transition between old and new medicine that forms the central, driving dynamic of the story. When leaving his office for the patient’s home, the doctor reaches for his old satchel and says “I picked up the relic from where I had tossed it two or three years before under a table in my small

laboratory hoping never to have to use it again.” Here, the word “relic” combined with the references to passing time show the bag to be an artifact of an era passed, buried in the doctor’s much newer “laboratory.” The doctor even explains that he “dusted off the top of the Lysol bottle” when retrieving it, reviving his outdated materials in order to go back in time to another style of medicine. Even the physician’s clothing demonstrates the differences between old and new practice, as he “went off without a coat or a necktie, wearing the same shirt I had on during the day preceding,” showing the informality of the house-call that contrasts with the sterile and professional hospital environment (CS 137).

Despite his turn to traditional methods in the old-style medical exchange that he is called to complete, the narrator’s inclination towards the scientific outlook and his status as “a physician who enjoys the technical aspects of his job” also appear in select moments of the narrative (Crawford *MMWCW* 103). For example, when he unloads his satchel in the patient’s home, he explains that “everything was ample and in order,” and even “complimented myself” as he finds “nothing so satisfying as a kit of any sort prepared and in order even when picked up in an emergency after an interval of years,” demonstrating his inclination towards the organized efficiency characterizing the new scientific medicine (CS 138). The doctor-speaker in one of Williams’s early poems, “Le Médecin Malgré Lui,” also describes the organizational state of his medical tools, revealing his instruments’ messy disorder and his office’s unkempt status, and thus providing a sharp contrast with the deliberate efficiency of the narrator in “A Night in June.” In this poem, the physician states his need to “wash the walls of my office,” “clean the bottles/and refill them,” “put/my journals on edge instead of/letting them lie flat/in heaps,” and begin “cataloguing important/articles for ready reference” to make his space clean and orderly. Though he frequently repeats the lines “I suppose I should” as he lists such necessary

organizational tasks, he shows no real intent to complete them. The speaker ends the poem by asking “who can tell?” as, unlike the physician in Williams’s later story, he shows little reverence for organized efficiency (*CPI* 122).

As “A Night in June” continues, the tensions stemming from the conflict between intuitive practice and scientific protocol dramatically assert themselves in a dream that the physician has when dozing off while his patient rests. He reports that “in my half sleep, [I] began to argue with myself—or some imaginary power—of science and humanity. Our exaggerated ways will have to pull in their horns,” as he recognizes the increasingly divided nature of the medical world and wavers in his preference between its conflicting styles. At first, he leans toward the old medicine, realizing “we’ve learned from one teacher and neglected another...science, I dreamed, has crowded the stage more than necessary.” However, he also recognizes the benefits of improved technology, thinking “without science, without pituitrin, I’d be here till noon” as he notes that new scientific medications—such as the pituitrin that will speed the woman’s labor—make treatment more timely and convenient (*CS* 141). As Monteiro argues, in this dream the physician’s internal “antagonism is playing itself out.” His emotional reflections on the importance of the patient’s humanity “threaten to break through the technique with which the doctor practices his artful science,” as the interpersonal nature of the old medicine imposes on the purely scientific emphasis of the new (Monteiro 81).

The narrative reaches a dramatic crossroads that fully immerses the doctor in the intuitive versus scientific medicine conflict when the woman reaches the final stages of her labor. Even after he “increased the dose of pituitrin,” she makes little progress, as the “still larger dose” causes “stronger pains, but without effect.” With this failure of scientific medicine, Williams’s narrator turns to less technical methods, reaching out to the patient and engaging in direct

physical contact in which he uses his own body to aid in the delivery. He explains that “I used my ungloved right hand outside on her bare abdomen to press upon the fundus,” and describes his teamwork with the patient when he says: “the woman and I then got to work. Her two hands grabbed me...about the right wrist and forearm.” Such a physical partnership that intimately links doctor and patient contrasts with the divisive nature of the new medicine that places instruments and medication between them. The physician appreciates this deepened contact, saying: “I welcomed the feel of her hands and the strong pull” and explaining that “the flesh of my arm lay against the flesh of her knee gratefully” (*CS* 142). Breslin discusses the significance of the old medicine in this story when he argues that the “loving care with which Williams describes the birth” combined with “the precision with which he tells how this is done and the perfect timing established between the mother and the doctor all serve to convey his knowledge of clinical detail, his admiration for the cool, experienced mother,” as Williams’s shows the value of combining intuitive medical knowledge with patient contact in achieving medical success (*Breslin* 159).

When the baby is finally delivered, the physician must once again decide between his intuition and scientific protocol, as he debates whether or not to put drops in the newborn’s eyes. He deliberates: “Oh yes, the drops in the baby’s eyes. No need. She’s as clean as a beast. How do I know? Medical discipline says every case must have drops in the eyes. No chance of gonorrhea though here—but—Do it” (*CS* 143). Despite his knowledge that the eye drops are unnecessary, he chooses to follow standard protocol and “comes down on the side of science and technology” (*Crawford MMWCW* 105).

A telling moment at the end of the story points to an additional effect of combining old and new approaches to medicine, demonstrating that their interplay not only shapes a physician’s

practice, but his entire outlook. During his physical contact with the laboring woman, the doctor experiences a moment of reflection in which he admits that “this woman in her present condition would have seemed repulsive to me ten years ago—now, poor soul, I see her to be clean as a cow that has calves” (*CS* 142). Here, the doctor shows a new level of comfort with the woman and the birthing condition, both implying that the familiarity bred in their longstanding relationship has made him more at ease and suggesting that through his increasingly empirical outlook, the physician is able to see her through a purely scientific lens that removes his former repulsion.

A Library of Congress recording of Williams reading this piece aloud grants valuable insight to his perception of the fictional exchange and the nature of the doctor’s divided engagement between scientific and personal medicines (*Pennsound*). For example, when reading the dialogue with the birthing woman, Williams presents the physician’s voice as gentle, emphasizing the value of calmness in an interpersonal approach to medicine. When the story shifts to describe medical procedures or instruments, Williams’s tone becomes distant and matter-of-fact, as he speaks sharply and methodically to show that science has taken over the physician’s line of thinking. When Williams narrates the physician’s debate over the dose of pituitrin to give his patient, he uses an intellectual tone to point out the mentally demanding, heavily focused nature of the new scientific medicine. When he later reads about the doctor’s contact with the birthing woman, however, Williams speaks in a more enthusiastic and fast-paced tone that contrasts with that used in his reading of technological elements, highlighting the energizing nature of physical contact while pointing to the importance of direct partnership in the medical exchange.

Like the narrator of “A Night in June,” the physicians in “Old Doc Rivers” practice at a time of transition in medical science and in society as a whole. In this frame-narrative story, the

narrator—a young doctor studying under the title character, Doc Rivers—details a selection of incidents as he reflects on his mentor’s practice. This format allows the story to follow the trajectory of Rivers’s medical world over time to reveal Rivers’s development as a physician and trace parallel changes in medical practice. As Breslin explains, “the entire story is framed historically,” as the young narrator “tries to assess the man’s social and historical position” (Breslin 148). Many comments by the narrator and the townspeople with whom he converses draw the story into the past, exemplified by quotations such as: “Yes, I can remember;” “You know how it used to be;” and “this is the story he told me” (CS 93).

Before arriving at the medical elements of the narrative, the narrator sets the scene of passing time, opening with the line: “Horses...along with the bad roads and the difficult means of communication in those times” to point out the conditions of the era. The narrator states that such conditions “definitely should be taken into consideration in estimating Rivers’s position,” as he asks the audience to remain conscious of historical change (CS 77). The transitional nature of the story arrives at the medical context when the frame narrator describes looking into hospital record-books listing dates and information on previous physicians’ deaths, symbolically pointing to the death of old medicine itself and indicating the passing from one era into another (CS 81).

As the young doctor proceeds with the tale, he describes a diverse series of Rivers’s cases. Though these memories explore multiple aspects of the doctor-patient relationship, they especially show the various means of treating patients in an evolving world of medicine in which science and intuition clash. As the narrative reveals, this conflict in changing medical practice had an especially significant impact on country doctors like Rivers, and on Williams himself.

In one of the story’s first patient-encounters, Doc Rivers must choose between answering a call from the hospital and treating a local patient. At the beginning of the scene, “the phone

rang...one of the first in the region,” showing new technology edging its way into Rivers’s world as it tells him that he is “wanted at the hospital.” When Rivers prepares to answer this call, his assistant tells him “there’s a woman out there has been wantin’ to see you for three days... She’s been here all morning,” revealing the great need Rivers’s local patients held for him (CS 78). Rivers wastes no time in choosing to treat the needy woman before going to the hospital, as he says “get her in” and makes “a quick examination, slipping on a rubber glove without removing his coat” to treat the woman in an exchange “that hadn’t taken six minutes.” As these quotations demonstrate, Rivers prioritizes his local patients, but still treats them with the efficient style characterizing the new medicine. Additionally, he still sees the hospital as an important medical establishment, as he instructs this patient to “get up to the hospital in the morning” and “pushed her out of the door” as he heads off to the place himself (CS 78, 79).

Another of Rivers’s patients is a young boy suffering from diarrhea. Though “several doctors had seen him and prescribed medicine,” the boy had failed to get better, so “they called in Rivers,” whose wider-ranging perspective provides new possibilities for a cure by extending beyond the tenets of science to unite mind and body in a more comprehensive diagnosis. The narrator even declares “and what a psychologist he was” as he explains how Rivers’s ability to see beyond the child’s basic medication needs leads him to prescribe circumcision and an accompanying dietary change, from which “of course the kid got well” (CS 83).

When Rivers later treats five-year-old Virginia Shippen for deadly kidney complications following a bout of scarlet fever, he brings a new element to his unique clinical methods: emphasizing a patient-centered partnership in care. Though Rivers “came in day and night, did—as he thought—everything he could to save her,” Virginia remained unwell (CS 86). He initially becomes discouraged, telling the family “that he was through,” until the mother “asked if he

would object if she made a suggestion.” Though her homeopathic idea “to try flaxseed poultices over the kidney regions” turns sharply from science, Rivers tells her, “go ahead,” as he listens to his patient’s needs and shows his old-school medical style that sees beyond rigid protocol to treat the family as partners in care. When “the next day the child’s kidneys had started slowly to function,” the benefits of home remedies show even more powerfully, as “Rivers was delighted, praised the mother and told her that she had taught him something” (CS 87).

Though Rivers’s trust in an intuitive, sometimes unorthodox medicine often results in successful treatment, the narrator also reveals its downfall. When combined with Rivers’s serious drug and alcohol addiction, his homeopathic style often leads him to take risky actions that jeopardize the patient. In one instance, the narrator describes assisting Rivers in surgery on an unusually large patient with appendicitis. The problems inherent in his home-treatment appear immediately, when they arrive at “the little house where he lived” and see that “the only room big enough to handle him in was the parlor.” Despite the environment’s insufficiencies, Rivers and his team “rigged up a table” right in the middle of the house—away from the hospital and the medical resources necessary for the challenging case. The conflict worsens when the narrator realizes that “ether wouldn’t touch this fellow any way you gave it—unless it might be by a tube”—a lab-based material which Rivers and his team do not possess (CS 83).

Rivers’s methods stray even farther from conventional modern surgical protocol when the young physician’s attempts to anesthetize the patient continue to fail. Without a fully sedated patient, the intended procedure becomes nearly impossible, as with every attempt at an incision “an earthquake occurred under our grips” when the man writhes in pain. Rivers’s solution to home-based medicine’s inadequacies involves overmedicating the man, as he “took the chloroform bottle and poured the stuff” into the man’s mask, while ordering the other doctors to

simply “hold him down and go to it.” Without even scrubbing their hands—as “asepsis had gone to the winds”—they restrain the patient as if he were a wild animal. “One man held his head and arms,” while the narrator lay “on my stomach across the man’s thighs,” leaving “one man, alone,” to perform the appendectomy unassisted in a hazardous manner that disregards science and safety (*CS* 84-85).

Though this patient survives the treatment, despite admitting to feeling pain for “every bit of it,” some of Rivers’s other patients are not so lucky. In another home-based appendectomy, Rivers continues his old-style practices, having “the kitchen already rigged up as an operating room” while “the instruments were boiling on the gas stove” (*CS* 85). When the sick old man enters with his wife, Rivers’s alcoholism combines with his sometimes dangerous old-style of medicine to further complicate the case. He “asked the wife if she had any more of that good whisky...and poured himself nearly a tumberfull.” Rivers even “held up the flask...toward his confrere,” offering his colleagues a share in the drink as if participating in a relaxed house party rather than a serious medical procedure. The narrator admits that from this point on, the surgery went only “more or less, according to the usual operating-room technique of the time,” showing how Rivers’s informal outlook leads to a disregard for science, efficiency, and protocol. In fact, when Rivers sees during the surgery that “it was a ruptured appendix with advanced general peritonitis,” he casually “shrugged his shoulders” in what seems an overly-casual response to a situation requiring professional action. Though the narrator recognizes that Rivers’s choice to place a drain and end the procedure was “the right thing to do,” “the patient died the next day,” causing “howl about the town” and sparking doubt in Rivers’s non-scientific techniques (*CS* 86).

The story’s commentary on the conflict between old and new medicine is summarized when the narrator meditates upon Rivers’s practice and the intermingling of science, art,

intuition, and clinicism in the changing medical world. He reflects “it is a little inherent in medicine itself—mystery, necromancy, cures—charms of all sorts, and [Rivers] knew and practiced this black art.” The narrator also admits that such unscientific practices in the “black art” of Rivers’s technique made it so that “toward the last of his life he had a crooked eye and was thought to be somewhat touched,” illustrating the community’s developing sense of confusion around his methods and even their doubt in his reputation, all speaking to the larger conflict between scientific and intuitive medicine (*CS* 101). Furthering the narrator’s statements on Rivers’s eccentric techniques and perspective, Crawford explains: Doc Rivers is both “the last of the snake oil quacks,” and, at the same time, “the prototype of the modern suburban physician,” as, like Williams, he is “caught between two worlds—the doctor trained in laboratory technique and the rural practitioner who depended on the uncertain effects of an ‘unscientific’ pharmacopeia” in his home-based practice (Crawford *MMWCW* 23, 5). After all, though Rivers spends the end of his life in a house with “a double garage” holding “two cars” that replace his buggy, “he himself never sat at the wheel,” providing a final image of Rivers embodying the tension separating old and new (*CS* 105).

Revisiting another of Williams’s short stories—“Jean Beicke”—adds further perspective to his commentary on old versus new medicine. Here, Williams’s narrator not only wrestles with balancing objectivity and empathy, but also with balancing scientific protocol and medical intuition. The story’s physician is technologically focused in his diagnostic practice. He uses medical language to list his science-based diagnostic plans and their outcomes, such as when he explains “I wanted to incise the drums, especially the left” and states that “the X-ray of the chest clinched the diagnosis of bronchopneumonia” (*CS* 161, 162). As the narrative progresses, these descriptions of medical proceedings continue to reduce Jean to a scientific object, as the

technology of medicine overcomes the interpersonal elements of practice. When the narrator laments Jean's failure to improve, he bases his analysis on physically-testable phenomena such as varying cell counts, fluctuating temperature, and inconsistent serum tests, rather than noting changes in her demeanor or behavior. It is here—when Jean's condition rapidly deteriorates—that science begins to fail the narrator and his team, as various medical procedures prove ineffective. Though they “did another lumbar puncture and...that was fine” and “the second X-Ray of the chest showed it was somewhat improved,” Jean's “temperature still kept up and we had no way to account for it.” As he flounders in his diagnostic proceedings, the narrator notes that “we did everything we knew how to do, except the right thing” (CS 162).

When Jean Beicke dies, the limits of the doctors' overly scientific outlook and their failure to examine the whole picture come to light, demonstrating the negative outcomes that can stem from the conflict between science and clinicism. When the doctor asserts that “we went over her six or eight times, three or four of us...and nobody thought to take an X-ray of the mastoid regions,” he reveals that Jean's death is ultimately due to a major medical misstep. He reflects on this mistake in the line: “It was dumb, if you want to say it, but there wasn't a sign of anything but the history of the case to point to it,” as he attributes their failure to take the crucial X-Ray to his team's disregarding of information from a key source: patient history. Instead of considering this vital element of diagnosis, the doctors defer directly to present laboratory results, as their emphasis on pure science over a more well-rounded approach leads them to bypass valuable steps in the treatment process that could lead to a lifesaving diagnosis. The doctor, does, however, learn from this experience. He explains that though Jean's ear-test results “showed no change from the normal” he could have examined her further, explaining “we might, however, have taken a culture of the pus when the ear was first opened.” Here, he recognizes the

value of taking extra precautions and considering the whole picture of the patient's condition, which he intends to do "always, after this, in suspicious cases" (CS 163).

The end of the story continues to comment on the doctor's scientific treatment of Jean, as he performs an autopsy to further assess her medical status. This procedure shows the pervasive influence of science in medicine, as even in death, Jean's body is a medical specimen to be studied and examined. As Bremen explains, the narrator's "lack of empathy combines with his failure to diagnose the illness properly in a reduction of the infant Jean onto the autopsy table" (Bremen 105). Although the physician passingly admits, "I never can quite get used to an autopsy," he performs the task and reports his findings with painstaking detail. At first, he explains "how completely the lungs had cleared up....almost normal except for a very small patch of residual pneumonia" and emphasizes the "excellent shape" of the chest and abdomen. When he and the pathologist reach Jean's brain and discover the explanation for her death, he deepens his hyper focus on science, as he uses even more specific medical terms to explain that "when the pathologist... opened up the left lateral ventricle," he noticed "just a faint color of pus on the bulb of the choroid plexus" and saw that "the left lateral sinus was completely thrombosed....the left temporal lobe from the inside of the mastoid process was all broken down." With these newly discovered details "the diagnosis all cleared up quickly," pointing to the physician's continued reliance on science to understand Jean's case (CS 165). In a final illustration of the conflict between a purely scientific outlook and a holistic focus on the whole patient, the doctor narrator responds to the pathologist's discovery that Jean may have been savable by asking: "For what?" still seeing Jean as a medical object rather than as a human patient with purpose in the greater world (CS 166).

Williams's unpublished drafts of the story "Comedy Entombed: 1930" from Yale University's Beinecke Rare Book and Manuscript Library further reveal his perspective on the complicated role of science in the medical world. A comparison between the published story and its working drafts show that Williams revised the story to make it more focused on the characters and their personal experiences rather than on the scientific elements of their medical interactions. For example, Williams added sensory adjectives to depict the story's setting while taking out less vivid details, and also replaced overly-general pronouns with more specific terms. For instance, he changed the physician's statement of the "young boy came up to me" to the young boy "came up to my side" in a much more personal description ("Comedy" Beinecke 4). In addition to these smaller changes, Williams also removed scientific elements from his portrayal of the doctor-patient exchange to make it more rooted in interpersonal connections and traditional home-based medicine. In an early draft, Williams edited out a paragraph in which the narrator encourages his female patient to go to the hospital, and also removed statements in which the doctor tells his patient that the hospital "would've been safer," and is "the only place for these cases" where "I can have things the way I want 'em," unlike the house-call environment in which he ultimately treats her ("Comedy" Beinecke 5). These statements' absence from the published work suggest Williams's acknowledgement of the value of home-medicine and other alternatives to the hospital's less patient-centered and more laboratory-focused protocol of care.

Williams also cut many sections describing the medical instruments and techniques used in treatment, making the story's final version more focused on interpersonal relationships than on medical details. From the scene when the physician arrives at his patient's home, Williams removed a section in which the doctor asks for "cotton, water basins, Lysol, boiling water, and a rubber sheet" ("Comedy" Beinecke 6). He also cut an excerpt listing the contents of the doctor's

bag along with a portion explaining his concern for protecting his clothes and subsequent choice to wear rubber gloves during treatment (“Comedy” Beinecke 8, 11). With the removal of such procedural details, Williams transformed his story from one focused on science and engaged in the methods of efficient, laboratory-based medicine to instead communicate the value of older, home-based practice.

Williams’s 1928 novel, *A Voyage to Pagany*, offers an exploration of the developing world of modern medicine, as it details the European travels of an American doctor looking to expand his medical education. Harry Levin states in his introduction that throughout the very autobiographical novel—which is largely based on Williams’s own medical studies abroad—Williams “remains his unaffected self,” thus making the work revealing of Williams’s own medical views and experiences in the changing medical scene (Levin xx).

For both Williams and his main character, Dev Evans, education in the scientific hub of Vienna provides both a means of keeping up-to-date on medical technology and an opportunity to reflect on changing medical practice. Evans himself tells some companions during dinner at the European hospital that “he had come to Vienna, as do so many doctors from the States, to observe new methods, to check up on his diagnostic technique, and to prepare himself for new adventures in his profession...and renewed interest in his work” (*VP* 143). In his educational efforts, however, Evans finds that Vienna’s position on the cusp of medical modernity makes its procedures appear harsh and cut-off from patient interactions, as its physicians focus instead on using the advanced technology available to them. In describing the European physicians around him, Evans notes that “sometimes the strange inhuman art of curing which possessed these men, so differently from Americans, seemed to reflect too harshly the difference between them and his

own soft western kind,” articulating the difference between Evans’s local clinical medicine and what he feels is the “inhuman” style of practice in Vienna (*VP* 156).

In this novel, one of the main traits characterizing European medicine’s method is its intense focus on physical symptoms and reliance on empirical observation alone. While observing the practice of the doctors around him, Evans watches as “tongues were projected, men were turned upside down, women were exposed in minutest detail to the last recess, eyes, nose, mouth, fingers, toes; ulcerated, blistered, and stained...nothing remained that was not seen, described and—a clarity put upon it,” showing how pure scientific observation characterizes the European technique (*VP* 155). As his study of the European doctors’ practice progresses, Evans continues to struggle with the traits of its modern medicine. He sees its highly scientific method as cold and dehumanizing and often watches in shock and frustration at his mentors’ focus on science alone. For example, when one of the German doctors treats an older male patient, he completely disregards the relational side of the patient exchange and treats the man as if he were an unfeeling object. In this incident, “the fellow was stripped in front of everyone...They let the old man lie on a cold metal table for nearly half an hour,” until the doctor finally begins the procedure in which he “nonchalantly took up a chisel and a mallet and with one mighty whang was in the middle of the bone soon gnawing away with his rongeur like a beaver.” After witnessing such harsh treatment, “Evans gasped thinking of the nice, timid, immaculate methods at home,” as the contrast between scientific and interpersonal medicine becomes especially dramatic (*VP* 156).

Furthering the tension-causing power of clinical science and objectivity in the world of European medicine is that, for Evans, “nowhere was he so overcome by this overwhelming mood of science as in the course on pathology of children” (*VP* 157). In this course, Dr. Kern, one of

the hospital's chief children's physicians, teaches classes in which the students "saw and analytically dissected these sad bits of humanity on all stages of illness, recovery, and dissolution," objectifying patients and transforming them into dissectible samples (*VP* 181). In one specific instance, a child was "brought in cowering, the tears streaming down her face from anguish and shame... Kern patted her, but there she stood and was turned and inspected—studied while she cried and bit her lips." Evans explains that all this harshness "seemed pitiless, but there it was," demonstrating how his European counterpart's cold treatment of the sick children ignores patient needs in favor of science (*VP* 155).

Despite his shock at the patient suffering caused by this scientifically-focused practice, Evans is intrigued by the innovative, exciting nature of new medicine, adding another layer to the tension he experiences between his own older methods and those of modern practice. When he arrives in Vienna, Evans is drawn to its advanced medical instruments, as exemplified when "he paused again before an optical instrument shop and admired the array of photographic and laboratory material" (*VP* 141). He is also fascinated to learn of groundbreaking new procedures, such as treatments for malaria and skin tests for tuberculosis.

As he proceeds to observe the actual physicians in Vienna—rather than simply study their materials and methods—Evans faces powerful cognitive dissonance as, in many ways, his rising horror at their practices is overcome by his desire for knowledge. After watching his Austrian teachers systematically dehumanize patients, "he shuddered...and would have turned back, had he not been so eager to know more." Additionally, while "at the very beginning, the trays of specimens, passing in the hall made Dev turn away," the teaching doctor's method of explaining new practices "carefully, lucidly demonstrating point by point," made him so fascinated that "everything else was forgotten" (*VP* 157). During a lecture by the lead doctor

towards the end of Evans's time in Vienna, "Dev was lit with excitement by this speech... his mind picking up each word as a magnet picks up needles" until "he was overcome with admiration," demonstrating the allure of scientific innovation, which, despite its contrast with the deeper and more personal nature of a patient-based exchange, wins Evans's regard (*VP* 212).

In addition to this novel, some of Williams's poems also examine the contrast between the old interpersonal and relational medicine and the new scientific and efficient medicine as the two styles interact in the doctor-patient exchange. "A Cold Front" tells of a struggling mother with seven children, who bluntly asks her doctor for pills for an abortion. While contemplating her request, the doctor considers her personal situation and living conditions, noting the poverty and stress that surround her and weighing these patient-centered factors in his response. After observing her "dead face" and "expressionless/carved eyes" looking in distress at her other children, who are described as "tormentors" surrounding her, he realizes the urgency of his patient's circumstances. He then decides that "in a case like this I know/quick action is the main thing," as he turns to scientific medicine as the best solution to her simultaneously personal and medical problems (*CP2* 92). In "The Birth," Williams describes a doctor and patient engaging in an intimate partnership based on direct verbal and physical communication that contrasts with the distant, laboratory based approach. Here, the doctor relies on old methods to guide the mother through her delivery. He follows her progress with his own senses rather than technological tools and uses household materials rather than advanced instruments in her treatment. Williams explains that he "watched/her pendulous belly/ marked/by contraction rings" to follow the development of her labor and even "got me a strong sheet/wrapped it/tight around her belly" to force the baby through the birth canal, ultimately resulting in a successful birth and pointing to the value of intuition and homeopathic methods (*CP2* 346).

Williams's own perspective on the interplay between patient-centered and technology-based approaches to medicine was largely shaped by his medical education at the University of Pennsylvania. Crawford explains that in his schooling at Penn—a leading institution in turn-of-the-century medicine—Williams was able to study under an innovative approach that simultaneously promoted the most up-to-date technology while maintaining a holistic perspective that reached beyond the realm of science. In fact, one of the textbooks that Williams often cites as most crucial to his education—*The Principles and Practice of Modern Medicine* by Sir William Osler—specifically addresses the question of whether medicine is a science or an art (Crawford *CCWCW* 176). Osler's philosophy, which emphasizes a patient-centered medicine, taught Williams lessons such as: "Listen to your patient; he is telling you the diagnosis," and "the good physician treats the disease; the great physician treats the patient who has the disease," marking Osler's work as one influential source leading Williams to place heavy value on patient relations (Osler). Penn's curriculum also taught Williams to incorporate technology into his practice. Crawford explains that at Penn, "education now took place not only in the medical building...but also in the labyrinthine laboratories," so that "the truth of disease is understood, not through the body of the patient lying sick in his or her own home, but instead through the examination of that patient's cells on a microscope slide," as advanced science combined with patient engagement to complete Williams's multi-sided perspective (Crawford *MMWCW* 37).

As Williams continued his education and practice—interning in the poorest sections of Philadelphia and New York, studying in Europe to advance his knowledge of technology and procedure, and settling in Rutherford where he mainly worked with local families in a highly relationship-based practice—he increasingly favored the old form of medicine with house-calls and interpersonal interactions over the laboratory-based medicine of the hospital. Cohen speaks

to the influence that Williams's experiences as a town physician had on his perspective, claiming that with his local practice, Williams "knew their homes and their lives, their struggles to survive economically" and focused on "their disease and disfigurements stemming from medical neglect and poverty" rather than from pathological causes alone (Cohen 66). Crawford characterizes Williams's distinction between medicine and science, explaining that "his numerous statements regarding science seem overly dismissive and, at times, incoherent," in a distaste that is largely due to science's "practice of creating abstract categories," which Williams saw as having no place in the concrete, objective world of medicine (Crawford *MMWCW* 39).

In explicitly expressing his frustration with science in *The Embodiment of Knowledge*, Williams often refers to the inadequacy of the abstract knowledge that it brings, explaining that the facts arising from scientific study are not rooted in the body or in experience. Crawford, however, points out the problem with this outlook, stating: "the desire to see the object clearly is fraught with difficulty," as he asserts that in "the history of medicine (particularly anatomy) ... there is a need for hands-on examination of patients and charting of symptoms, but medical science must also create abstract models of pathology," showing how medicine requires both observation-based knowledge and abstraction (Crawford *MMWCW* 33).

The elements of efficiency and cleanliness emphasized by the new medicine of the 20th century also link to broader changes in an increasingly technological society. Many of the era's ideological changes manifest themselves in the focus on precision and clarity characteristic of some modern poetry, providing a cultural and ideological link between Williams's two careers. In discussing the parallels between such modernist poetry and modern medicine, Crawford asserts that "the modernist doctrine of speed, mobility, clean lines, and clarity most often associated with the Futurists and the Purists or with automobiles and airplanes, was part of the

rhetorical strategies directed towards the physicians as well” (Crawford *MMWCW* 87). Under this new doctrine, poets and doctors came to view their respective tools similarly, as the physician’s emphasis on treating symptoms as individual things parallels Williams’s and fellow modernists’ treatment of words as things. Crawford further explains that clarity and cleanliness are “specific and remarkably common concepts in Williams’s writing, in medical texts, and in the discourse of Modernism in general,” as he ties Williams’s use of unbiased observation in medicine with his emphasis on clean language in literature (Crawford *MMWCW* 8). Hugh Kenner, in the Annenberg Foundation’s documentary on Williams, further links his modernist poetics with his medicine, explaining that “observing of the absolutely commonplace,” which was Williams’s ultimate goal and motivation in poetry, is also a very “medical discipline” (Voices and Visions).

This practical and ideological similarity between modern medicine and literature is one of many parallels that fuse Williams’s two worlds. For both his physician-narrators and for Williams himself, dynamic interactions between emotion, science, and observation in the medical realm stir largely unresolvable conflicts that make the doctor’s job of providing effective treatment—which involves marrying scientific and interpersonal approaches to both utilize advanced technology and view the patient as a whole person—extremely challenging. It is through writing, the very means by which Williams explores these conflicts, that he attempts to find a way to mediate them. Through its required combination of pure observation and emotional expression that draw on culture and human experience, creative writing enabled Williams to maintain his scientific outlook while bringing it into an imaginative setting that allowed for engagement of the personal. As Ivan Iniesta, a neurologist writing for fellow doctors in *Clinical Medicine* explains, “for Williams, medicine and poetry worked in symbiosis. Thanks to poetry,

he was able to transform medical jargon into a more comprehensible narrative. On the other hand, medicine helped him set his priorities straight and prevented a detachment from reality, thus making concision and objectivity the hallmarks of a personal poetic style” (Iniesta 92). For Iniesta, poetry helped Williams to transform the science of medicine into a more universally human-based concept and surpass the otherwise confining nature of technological practice, allowing Williams to find an avenue for cultural and personal understanding that brought him closer to both his audience and his patients. Iniesta’s point is also true of Williams’s prose.

The most significant means by which Williams’s writing took him beyond science is in his emphasis on local culture, as such an engagement with his patients’ worlds provided a way to relate to them beyond observation and scientific medicine. The main avenue by which Williams achieved this cultural connection is through listening to and illustrating local language, which he asserts “is the storehouse of the traditions of the people” (*EK* 117). Thus, in his quest to express what in the 1950s he would term “The American Idiom,” Williams also immersed himself in what he viewed as one of the most important elements of his patients’ existence. Breslin explains that in Williams’s prose and poetic expression of local linguistic patterns, “we get a spare, swift-moving colloquial language that has been purged of all stylistic pyrotechnics,” whose “simplicity of manner opens Williams’s fiction to the lives of the people in his locality”—demonstrating how linguistic expression brought Williams closer to the patients from whom the science of medicine often separated him (Breslin 138). Crawford also explicitly applies Williams’s engagement with the local world to improving his medical practice when he asserts “[Williams] might have a ‘philosophy of disease,’ but it is rooted in his place of practice, not in the arid abstractions of medical theories” (Crawford *CCWCW* 179).

Williams's patient interactions themselves actually served as his main source of contact with the local language and culture so valuable in extending his medical practice beyond the scientific realm and in negotiating the conflicts inherent in his career. In his account of shadowing Williams in his daily practice, Robert Coles recalls Williams describing the local context he garnered from his house calls. Coles quotes his mentor's advice to "look around, let your eyes take in the neighborhood —the homes, the stores, the people and places, there waiting to tell you, show you something" (Coles 8). Breslin further explains this intertwining relationship between Williams's medical practice and the cultural observation he used to enrich it when he asserts that "the practice of medicine clearly deepened his involvement in the life of his locality, offering the writer intimate contact with the lives of its inhabitants and eventually opening up a new world for literary exploration," claiming that not only did local engagement aid Williams in his medical career, but his use of the experiences within that career to enhance such local engagement simultaneously enriched his writing (Breslin 9).

Medicine, therefore, gave Williams a window into the world of his patients, whom he saw as embodying the diverse local culture on which he relied to bridge the gap between science, professionalism, and emotion in his medical practice. As Williams explains, "my 'medicine' was the thing which gained me entrance to these secret gardens of the self... I was permitted by my medical badge to follow the poor, defeated body into those gulfs and grottos," showing his recognition that through patient interactions, he entered a world of raw, unapologetic humanity that, if properly comprehended, provided him insight on the patient condition that transcended the reach of science (*Autobiography* 288). Donohoe summarizes medicine's power to bring a physician in contact with the human experience and enhance his ability to relate to patients when he explains, "Williams sharpened his diagnostic acumen and magnified his insight into the

human condition through his ability to immerse himself in his patient's medical and social problems" (Donohoe 16). Donohoe emphasizes the importance of this lesson to his fellow physicians by beginning his article with the statement that "many of Williams's concerns continue to affect today's physicians, and his observations and advice possess immense value for those interested in ethics and humanism in medicine," pointing out the significance that Williams's outlook holds for improving medical practice and perspective (Donohoe 12).

One of Williams's lesser-known stories, "Ancient Gentility," explores the ways in which a physician's willingness to engage in his patients' lives and culture by looking beyond scientific and professional standards immerses him in a world of human experience that transcends the limits of his medical occupation. The patients in this story come from an impoverished New Jersey community of "Italian peasants...living in small, jerry-built houses—doing whatever they could find to do for a living," similar to many of Williams's own poor, ethnically diverse patients (*CS* 273). When the physician-narrator makes a house call to an elderly couple, the mutual respect between the parties is clear. As the doctor arrives at the couple's home and is greeted by his patient's husband, the Italian gentleman "smiled and bowed his head several times out of respect for a physician," while the narrator describes the man as "wonderful...A gentle, kindly creature." Despite their reciprocal regard, the physician struggles to communicate with the old man, as "he couldn't speak a word of English and I knew practically no Italian," forcing the parties to resort to body language and other cues to cross the cultural gap and deepen their interpersonal connection. This nonverbal communication continues when the doctor treats the man's wife, who throughout the examination "said a few words, smiling the while, by which I understood that it wasn't much...that she didn't need a doctor" (*CS* 274). Here, even nuanced

communication through facial expressions and gestures is effective for both enabling diagnostic treatment and fostering interpersonal relationships.

This story's demonstration of the power of cross-cultural engagement to bring about an understanding of human nature concludes with the grateful gentleman showing his appreciation for the doctor's efforts in an unorthodox yet deeply meaningful exchange. Though he is too poor to pay the physician for his services and often expresses that he is "sorry he had no money," the man makes an offering of his own that reflects the realities of his world. After the first moments of their farewell, in which the two parties were "paused in one of those embarrassed moments ...between relative strangers who wish to make a good impression on each other," the Italian man "reaches into his vest pocket" and hands the narrator a small box. When the doctor fails to understand the gift, the gentleman reaches for it "ever so gently" and takes the "brown powder" within onto his fingertips to identify it as snuff and show the doctor how to consume the substance. The narrator exclaims, "I was delighted" as the two men—so generationally, ethnically, educationally, and socioeconomically separated—share the gift together in what the doctor describes as "one of the most gracious, kindly proceedings I had ever taken part in." Sharing such a simple experience with the gentleman brings the physician onto an equal footing with his patient and also provides him the opportunity, even if momentarily, to participate in the culture of the people around him. The physician recognizes the magnitude of the exchange when he calls it "an experience the like of which I shall never, in all probability, have again in my life on this mundane sphere" (*CS* 275).

Though the old man is unable to provide financial compensation for the doctor, their interactions instead provide much more: a deepened perspective, enhanced cultural awareness, and oneness with his human counterparts that enhances the doctor's ability to treat and to cure.

Donohoe explains that for Williams, like the physician in the story, “his patients showed him weakness and strength, cowardice and courage, and provided him an unparalleled opportunity to discover the nature of man” (Donohoe 13). Thus, for Williams himself, who at times went unpaid by his working-class patients, such interpersonal exchanges served to bring him closer to the people whom he treated, developing the relational side of his medical practice. Mariani explains that Williams refused “to send bills to patients who were finding it harder than he was to make ends meet in Depression New Jersey. Instead, they paid him back by barter or merely by their presence, their stories, their language, which—once out in his car again after a house call, or between office visits—he would transfer in a white heat to his prescription pads,” channeling the invaluable energy from his exchanges into creative production (Mariani 297).

This unity between Williams’s careers was crucial to him. Using lines from Williams’s autobiography, Bremen explains this oneness and further articulates the interplay between literature and medicine by observing that while “Williams’s writing revives him from the long hours of his practice,” “the prosaic ‘humdrum, day-in, day-out, everyday work that is the real satisfaction of the practice of medicine’ gives Williams the raw material in which he can discover the ‘radiant gist’ of his poetry” (Bremen 84). Williams himself wrote “I have never felt that medicine interfered with me, but rather that it was my very food and drink, the very thing which made it possible for me to write” (*Autobiography* 357). Thus, as Williams’s careers intertwined, he enriched his involvement and abilities in both, melding science, medicine, personal relationships, imagination, and culture into one dynamic discipline that shaped the existence of the physician-writer. In a letter to publisher Ronald Latimer, Williams even acknowledges a need for writing as a form of release from the stresses of his practice, stating “I run around through six townships and four boroughs chasing the little twos and threes until I

stink of all the international odors from garlic to *bouquet de cochon*. And in between I write poems for rest, relief and relaxation. My three Rs” (quoted in Mariani 399).

Thus, writing was Williams’s catharsis. Though not a solution to the unresolvable conflicts between objectivity, professionalism, emotion, and science that Williams explores in his literary works and experienced in his own medical practice, language and literature served to help relieve the strain such tensions placed on the physician—providing a way to calm, escape, and attempt to resolve the conflicts ever-present in his medical world. Through the two way exchange of both energy and respite that the separate fields provided for the physician-writer, his two careers became one in a unity that not only linked medicine and poetry, but science, humanity, and imagination. In medicine, as in his prose and poetry, Williams was always ready to “try hard,” and would ask the same of his patients and readers—for that way, together, they could maintain the hope of effective communication and productive relationships.

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